Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
RIO GRANDE CITY CISD

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-09-5841-01

MFDR Date Received
February 2, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit that they have not paid what we determine as a 'fair and reasonable' amount for this outpatient surgery… Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable… Based on their payment a supplemental payment is still due of $2815.16, at this time."

Amount in Dispute: $2,815.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment for this bill has been made at an amount greater than that specified by Texas Department of Insurance Division of Workers Compensation Rule 134.403."

Response Submitted by: HealthFirst TPA, PO Box 672447, Houston, Texas 77267-2447

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2008	Outpatient Hospital Services	$2,815.16	$2,222.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.3 sets out the requirements for communications between health care providers and insurance carriers.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 800 – Reimbursement is based on the applicable reimbursement fee schedule.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 97 – Payment is included in the allowance for another service/procedure.
   - 409 – Payment for this item or service is packaged into APC rates
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 850 – The reimbursement for this procedure was reduced based on 200% of the CMS APC payment rate.
   - W3 – Additional payment made on appeal/reconsideration.
   - FEE – CHARGE EXCEEDS THE FEE SCHEDULE ALLOWANCE
   - TEC – SERVICE APPEARS TO BE TECHNICAL COMPONENT ONLY

Issues

1. Did the respondent support the insurance carrier's denial of procedure codes 29879 and 29999?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier contends that "The codes shown upon the bill do not correspond with the codes billed by the attending surgeon and therefore no payment was made for 29879 or 29999." Per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the explanations of benefits (EOBs) submitted by the requestor finds that the insurance carrier did not indicate any denial code or present any reason to the requestor for denial of these services. The respondent has submitted a *Review Analysis* to medical dispute resolution which has the notation "DOES NOT CORRESPOND WITH SURGEON CODES." However, no documentation was submitted to support that this denial reason was ever presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Therefore, these newly raised defenses or denial reasons shall not be considered in this review. Additionally, per §133.3(a), "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill." Review of the submitted EOBs sent by the insurance carrier to the health care provider finds no communication of sufficient, specific detail to allow the provider to easily identify the reasons that the carrier denied procedure codes 29879 or 29999. The Division therefore finds that the insurance carrier has not met the requirements of §133.3(a). The respondent has not supported the insurance carrier's denial of procedure codes 29879 or 2999 and therefore these services will be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds that the disputed services are not subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for

the disputed services is calculated as follows:

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $11.83. 125% of this amount is $14.79. The recommended payment is $14.79.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $10.86. 125% of this amount is $13.57. The recommended payment is $13.57.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $5.49. 125% of this amount is $6.86. The recommended payment is $6.86.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $8.38. 125% of this amount is $10.48. The recommended payment is $10.48.
- Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 41, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9136 yields an adjusted labor-related amount of $1,004.85. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,738.10. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio multiplied by the billed charge of $12,314.00 yields a cost of $2,388.92. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,738.10 divided by the sum of all APC payments is 39.78%. The sum of all packaged costs is $1,953.19. The allocated portion of packaged costs is $777.07. This amount added to the service cost yields a total cost of $3,165.99. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $124.31. 50% of this amount is $62.16. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,800.26. This amount multiplied by 200% yields a MAR of $3,600.51.
- Procedure code 29876 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 41, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of

$1,099.88. This amount multiplied by the annual wage index for this facility of 0.9136 yields an adjusted labor-related amount of $1,004.85. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,738.10. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $869.05. This amount multiplied by 200% yields a MAR of $1,738.10.

- Procedure code 29879 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 41, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9136 yields an adjusted labor-related amount of $1,004.85. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,738.10. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $869.05. This amount multiplied by 200% yields a MAR of $1,738.10.
- Procedure code 29999 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 41, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9136 yields an adjusted labor-related amount of $1,004.85. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,738.10. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $869.05. This amount multiplied by 200% yields a MAR of $1,738.10.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 99, which, per OPPS Addendum A, has a payment rate of $24.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $14.87. This amount multiplied by the annual wage index for this facility of 0.9136 yields an adjusted labor-related amount of $13.59. The non-labor related portion is 40% of the APC rate or $9.92. The sum of the labor and non-labor related amounts is $23.50. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $23.50. This amount multiplied by 200% yields a MAR of $47.00.

5. The total recommended payment for the services in dispute is $8,911.26. This amount less the amount previously paid by the insurance carrier of $6,688.61 leaves an amount due to the requestor of $2,222.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,222.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent

to remit to the requestor the amount of $2,222.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	August 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.